

1 REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS<sup>□</sup>

2  
3 CEJA Report 3\_ A-01

4  
5 Subject: Filming Patients in Health Care Settings

6  
7 Presented by: Herbert Rakatansky, MD, Chair

8  
9 Presented to: Reference Committee on Amendments to Constitution and Bylaws  
10 (William J. Mangold, Jr., MD, Chair)

---

11  
12 Introduction

13  
14 Patient privacy and confidentiality of medical information are the bedrock of the patient physician  
15 relationship. A patient's knowledge that he or she can reveal personal information to a physician, and  
16 that the physician must keep this information confidential, is what enables patients to candidly disclose to  
17 their physician information that they might not want generally known. Knowing this information is what  
18 allows physicians to provide care effectively. This fundamental element of the patient-physician  
19 relationship is potentially compromised when film crews are allowed to film, videotape, or otherwise  
20 record, (hereafter film) patients in the clinical setting. Such filming has recently proliferated with the  
21 advent of reality-based television shows featuring health professionals.

22  
23 The laudable objective behind publicly broadcasting such films of patients is to inform and educate the  
24 public about the health care system and medical care. It is possible that this can even reduce injury and  
25 disease prevalence through education about risk factors. However this educational objective must be  
26 balanced against the competing and arguably more fundamental right to privacy and confidentiality held  
27 by patients.

28  
29 A potential compromise between public education and privacy may exist when patients consent to being  
30 filmed for the purpose of public viewing. However, when it is not possible for patients to consent to  
31 being filmed, for example when a patient arrives at an emergency department (ED) unconscious, there is  
32 no clear ethical consensus as to whether privacy can be compromised. Current practice appears to allow  
33 the filming to precede consent, and for consent to be obtained subsequently, but prior to the broadcast.  
34 Indeed, there appears to be a general consensus that it would be unethical to air any footage acquired  
35 without obtaining consent from the patient or the patient's surrogate decision-maker. However, it is  
36 unresolved to what extent the initial filming represents a breach of the patient's privacy and  
37 confidentiality.

38  
39 In this report the Council provides guidance regarding ethical filming of patients by discussing the scope  
40 of patient privacy and confidentiality; the responsibility to obtain informed consent; and the importance of  
41 ensuring the objectives in filming are first and foremost educational.

42  
43  
44 Patient Privacy and Confidentiality

45  
46 The areas of both privacy and confidentiality are important when contemplating the issue of filming and  
47 broadcasting patient encounters. In the realm of privacy, patients are ethically, and to a great extent

---

<sup>□</sup> Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 legally, entitled to have only those individuals who are involved in their medical care examine them, or  
2 observe their examination. Opinion 5.04, “Communications Media: Standards of Professional  
3 Responsibility” states that “Physicians are ethically and legally required to protect the personal privacy  
4 and other legal rights of patients.”<sup>1</sup> Thus the presence of the film crew may be an infringement of the  
5 patient’s privacy.

6  
7 Protecting confidentiality arises from the need of patients to share personal information with their  
8 physicians in order for them to provide medical care. This privileged communication is a voluntary  
9 surrender of privacy with the expectation that some control over the information is retained, namely that  
10 the information will not be disclosed beyond the person with whom it was entrusted, or to others directly  
11 involved in the patient’s care. According to Opinion 5.05, “Confidentiality,” information that is shared  
12 with a physician should not be further disclosed unless disclosure can be “ethically and legally justified  
13 because of overriding social considerations”,<sup>2</sup> or the patient gives consent to the release of the  
14 information. Exceptions that are contemplated by the Opinion include physical threats and other  
15 circumstances related to the potential harm of self or others, such as physical violence, and communicable  
16 disease. Also, according to Opinion 7.025, “Records of Physicians: Access by Non-Treating Medical  
17 Staff,” patients are entitled to have their medical information accessed only by individuals directly  
18 involved in their medical care.

19  
20 In considering the issue of filming, it is important to consider the general expectation of privacy in the  
21 health care setting and how this might be compromised by filming, particularly when individuals not  
22 necessary for the medical care of the patient are present.

#### 23 *Expectation of privacy in health care settings*

24  
25 First, it is important to note that the nature of the professional interaction between a patient and his or her  
26 physician renders this interaction private, and therefore there likely is an expectation that the setting in  
27 which the patient-physician interaction occurs, be it a hospital room or a private office, is a private rather  
28 than a public space.<sup>3</sup> *Blacks Law Dictionary* defines a public space as:

29  
30 A place to which the general public has a right to resort; not necessarily a place devoted  
31 solely to the uses of the public, but a place which is in point of fact public rather than  
32 private, a place visited by many persons and usually accessible to the neighboring public  
33 (e.g. a park or public beach). Also, a place which the public has an interest as affecting  
34 the safety, health, morals, and welfare of the community. A place exposed to the public,  
35 and where the public gather together or pass to and fro.<sup>4</sup>

36  
37  
38 Certain parts of a hospital might fit within this public space definition, but the immediate moment  
39 that a space is used for interaction between a patient and his or her physician renders that space  
40 private.

41  
42 This is important because courts have held that surveillance or recording without consent or court order is  
43 impermissible in areas where there is a reasonable expectation of privacy. In cases when the media have  
44 broadcast footage or published photographs of patients without their consent, courts have ruled that such  
45 broadcast or publication was an unlawful violation of privacy.<sup>3,5</sup> It does not appear that courts have yet  
46 ruled on whether the act of filming alone (without the subsequent broadcast) likewise constitutes an  
47 unlawful invasion of privacy. However, even if it is determined that similar legal protection is not  
48 necessary (because for instance, the potential harm in being seen by millions of people via broadcast is  
49 not the same as the harm in being seen by a film crew), this does not preclude the establishment of ethical  
50 standards to offer greater protection of patient privacy, and to also protect the patient-physician  
51 relationship from being hindered by third parties for purposes of questionable benefit.

1 *Presence of non-health care professionals*

2  
3 Another privacy and confidentiality concern involves the presence of film crews composed of  
4 non-health care professionals in the clinical encounter. Unless a stationary camera is used, or a  
5 health professional performs the filming, someone is present to film who is not essential to the  
6 medical care of the patient.<sup>6</sup> If the patient subsequently does not provide consent, this invasion of  
7 privacy cannot be undone. Furthermore, film crews, unlike health care professionals, are not  
8 bound by professional duties to keep medical information confidential. Thus, even if consent to  
9 broadcast was denied, and the tape destroyed, there is no guarantee that the film crew will  
10 maintain the confidentiality of the information they obtained as observers.

11  
12 Some physicians who have participated in filming of reality-based television shows contend that  
13 the crews blend in, and feel like "...an ancillary member of the team."<sup>7</sup> In fact, it may be very  
14 difficult for patients to distinguish members of the film crew from members of the health care  
15 team because the film crews may dress like the medical staff,<sup>8</sup> a source of concern for some.

16  
17 *Justifiable breaches of privacy and confidentiality*

18  
19 In certain circumstances, the "overriding social considerations" set out in Opinion 5.05 may warrant not  
20 only breaches of confidentiality but also an invasion of patient privacy. For instance, when a person is  
21 suspected of physically abusing someone under his or her care (often a child, but possibly the elderly or  
22 physically or mentally impaired), Factitious Disorder by Proxy (also known as Munchausen syndrome by  
23 proxy) must be considered, and it may be appropriate to implement covert video surveillance (CVS) to  
24 monitor for the occurrence of such abuse. Also, it may be beneficial for medical education purposes to  
25 film patient encounters or procedures with the understanding that such footage will not be publicly  
26 released. In the conduct of forensic medical examinations or interviews, particularly for psychiatric  
27 consultation, filming may be requested by the court. The conduct of telemedicine also often may result in  
28 a filmed record. Finally as a standard security measure, medical facilities often employ security cameras  
29 in corridors and other public areas.

30  
31 In the above scenarios, it is always desirable to obtain the patient's consent prior to filming, or at a  
32 minimum, disclose to the patient that filming will occur (although it is understood that if CVS is being  
33 performed, disclosure or consent would undermine the purpose of the filming). Additionally, impartial  
34 review by an entity such as an institutional review board or hospital ethics committee is an appropriate  
35 mechanism for ensuring that patients' rights are protected. After any patient footage has served its  
36 purpose, additional protection against unauthorized use is to destroy the tape.

37  
38 Additionally, in all the above scenarios the film is not made available for public viewing, but rather is  
39 narrowly used for purposes which have clear benefits to patients, the health care system, and society as a  
40 whole. When the use is for the education of medical professionals, the presumption of confidentiality  
41 (non-public viewing only), the ability to remove or obscure the patient's identity, the use of health  
42 professional or stationary cameras in performing the filming, and the ability to control possession of the  
43 footage, create circumstances that are significantly different from filming with the intent of broadcast for  
44 public viewing. The American College of Emergency Physicians (ACEP) Ethics Committee states:

45  
46 Recorded images that are used for education and training are in a different category.  
47 Here the audience is clearly not just the people who needed the information to further the  
48 patient's interests. One can argue, however, that the public good is served by educating  
49 physicians and others with the most accurate materials available. If the patient gives  
50 consent for this use prior to obtaining the images, and the audience is limited to persons  
51 within the bounds of this consent, then privacy and confidentiality expectations are met.

1  
2 Use of recorded images for training, if done automatically, or at least by someone who is  
3 part of the caregiver facility, may be appropriate. The process must be carefully  
4 controlled, and consent must be obtained before any use of the images. With these  
5 careful limits, it can be argued that the public good outweighs the problem of obtaining  
6 consent after the fact, and in any case the tapes are not released without the patient's  
7 permission.  
8

## 9 10 Informed Consent

11  
12 The discussion above illustrates patients' rights to both privacy and confidentiality and the physician's  
13 duty to protect these rights. Unless the patient provides informed consent, breach of privacy or  
14 confidentiality can only occur because of "overriding social considerations." In Opinion 8.08, "Informed  
15 Consent," the Council discusses a framework within which a patient actively participates in choosing  
16 among "therapeutic alternatives." The Opinion also recognizes that sometimes patients may refuse  
17 treatment all together.<sup>10</sup> Exceptions to obtaining consent are provided in relation to individuals who are  
18 "unconscious or otherwise incapable of consenting." Under such circumstances, treatment is undertaken  
19 based on the implied consent doctrine that a reasonable person capable of consenting would want to  
20 receive medical care that is in his or her best interests. However, since filming a patient confers no  
21 therapeutic benefit, this standard should not be applied to unconscious or incapable patients when the  
22 issue in question is filming.  
23

24 The process of obtaining informed consent is intended to allow the patient to make an informed decision  
25 based upon the likely risks and benefits of a course of action. Ideally, this assumes that there is sufficient  
26 time to explain precisely what the patient is consenting to, time to resolve any questions or concerns the  
27 patient may have, and time for the patient to reflect on the implications of what he or she is consenting to.  
28 When the filming is being performed with emergent patients it is ethically questionable whether it is wise  
29 to spend time obtaining consent for anything that is not of therapeutic benefit to the patient.  
30 Additionally, even if a patient is conscious, it is important to evaluate whether he or she is competent to  
31 consent to something that is not of medical benefit and poses a potential violation of privacy. The ACEP  
32 Ethics Committee notes that "An alert patient can presumably give ... consent, but the very nature of  
33 emergency medicine suggests that the patient is under some duress, which may cloud their thinking."<sup>6</sup>  
34

35 Since the objective of informed consent is to ensure that the patient is informed of all elements that they  
36 are consenting to, it is important to have more than one mechanism in which the information is disclosed.  
37 Thus, signs should be posted in and around the area where filming is to occur, indicating that filming is in  
38 progress. These signs are of benefit not only to patients but also to the medical staff, who should likewise  
39 have an opportunity to consent or object to being filmed.  
40

### 41 *When consent is denied or withdrawn*

42

43 Consent is a dynamic process, not a static one, and once a patient consents to filming, he or she reserves  
44 the right to rescind consent, right up until the time the footage is to be broadcast. This was established  
45 when the Federal District Court for the 9<sup>th</sup> Circuit ruled in *Virgil v. Time, Inc.* that "...if consent is  
46 withdrawn prior to the act of publicizing, the consequent publicity is without consent."<sup>9</sup> One way to  
47 ensure that patients do not have reservations about giving consent is to provide them with an opportunity  
48 to view the final edit of the material prior to it being broadcast.  
49

50 If a patient initially consents to filming and subsequently withdraws that consent, the highest ethical  
51 standard would be to destroy the filmed record. This would also apply in the less desirable scenario of

1 initial filming occurring without the patient’s consent, and subsequently the patient refuses to consent to  
2 broadcast. Another possibility that would protect patient confidentiality, although not privacy, would be  
3 to edit the patient out of the filmed record, or obscure visual and voice recognition of that patient.<sup>6</sup>  
4

#### 5 *Consent by surrogate decision-makers*

6

7 The utilization of surrogate decision-makers to provide consent for a party who does not have the capacity  
8 to consent typically involves two assumptions: (1) that it is necessary for a decision to be made one way  
9 or another (between two courses of action or therapies for instance); and (2) that absent any advance  
10 directive, the person in question would want medical care in his or her best interests which provides the  
11 greatest probability for a successful outcome. When the issue in question involves filming patients for  
12 public viewing, neither of the above assumptions can be affirmed—it is not necessary for the decision to  
13 be made for the person’s medical care, and the filming itself will not provide medical benefit.  
14 Furthermore, the domain of surrogate decision makers in the health-care setting is appropriately limited to  
15 making health-care decisions. For instance, because a surrogate is empowered to decide between  
16 therapeutic alternatives when the patient cannot decide, he or she would not automatically be empowered  
17 to sell the patient’s house. Thus it is not permissible to allow a surrogate to provide consent for the party  
18 being filmed. Consent must be obtained from competent patients themselves.  
19

20 A possible exception exists when the patient is permanently or indefinitely incompetent and a parent or  
21 legal guardian is legally empowered with the ability to make all decisions for that person using a best  
22 interests standard. Examples of such exceptions might include minor children, mentally retarded  
23 individuals, or persons in a permanent vegetative state. In these instances, if the parent or legal guardian  
24 provides consent, filming may occur.  
25

#### 26 *Is the film part of the medical record?*

27

28 One legal question that deserves some attention is whether once a filmed record is made, does it constitute  
29 part of the medical record? If it is considered part of the medical record, it would potentially be unlawful  
30 to destroy it. The federal Interagency Committee on Medical Records (ICMR) does not consider  
31 videotapes part of the medical record, although its policy is advisory and does not specifically mention  
32 footage taped for broadcast purposes.<sup>11</sup> Notably, the Joint Commission on Accreditation of Healthcare  
33 Organizations states in its policy clarification that absent consent, the filmed record should be destroyed.<sup>12</sup>  
34 Physicians should comply with local regulations pertaining to whether the film is part of a medical record,  
35 and should not destroy the tape if contrary to local law.  
36

#### 37 *Consent of Medical Staff*

38

39 While the medical staff are not in the vulnerable position that patients are in, filming can represent an  
40 invasion of their privacy. Furthermore, filming may be an especially sensitive area for those in  
41 undergraduate or graduate medical education and still developing their clinical skills. In these  
42 circumstances, filming may create a source of anxiety that could induce medical errors, although some  
43 physicians have commented that they slow down and are more careful when they are being filmed  
44 because they fear that a mistake may be recorded.<sup>13</sup> Other physicians have expressed concern about being  
45 filmed during emotional moments, such as the death of a patient.<sup>14</sup> For these reasons, every effort should  
46 be made to obtain consent not only from patients, but also to obtain consent from the medical staff.

## Educational versus Commercial Purpose

Some have argued that medical reality shows are educational and benefit the public. This issue has been discussed in light of fictional medical dramas, which sometimes give false impressions of medical care in general and “injury management and survivability” in particular.<sup>7</sup> Recent research has verified that these dramas can convey health information,<sup>15</sup> but that sometimes this information is inaccurate.<sup>16</sup> This raises concern about the educational purpose of these shows, and their responsibility to be accurate.

Additionally, the increased exposure that is provided for the medical center and the medical staff cannot be ignored. Referring to one of the recent programs, Jerome Kassirer, editor-in-chief emeritus of the *NEJM*, noted that “The program glorified the [medical center’s] staff...[and] seemed intended more for public relations than for public service.”<sup>17</sup>

Furthermore, many outrightly question whether the viewers of these shows have any “academic or clinical interest in emergency medicine,” but rather assert that “They watch the shows for the same reasons people gawk at accidents—out of morbid curiosity and prurient interest.”<sup>18</sup> In fact, the time slot during which one network features its shows is called “The Adrenaline Rush Hour” and its website encourages people to “experience the rush of life-and-death situations and intense conflict in and out of the emergency room.”<sup>18</sup> This may suggest that the audience for these shows are more likely be thrill seekers than those curious about medical care or the health care system.

## *Financial Compensation*

The majority of recent television shows featuring patients have been on commercial networks, indicating that profit making is an important motive behind the production of these shows. This raises the potential question of whether patients or the medical staff (who essentially star in these shows) should receive financial compensation for their appearance in the broadcast but raises additional questions as to whether compensation would constitute a coercive pressure for either patients or physicians to participate in filming. Factors that might be important include whether the broadcast was on a commercial or public broadcast station, the potential for revenue from the broadcast of the show, and who might receive that revenue. To ensure that such coercive pressure is not present, any remuneration or other form of compensation, such as reimbursement for the care that was received at the time of the filming, probably should be donated directly to the health care institution.

## Conclusion

Filming in health care facilities affords the opportunity to inform the public about the health care system, and even the possibility of reducing injury and disease through education about risk factors. While these are worthwhile endeavors, they are not of sufficient benefit to warrant undermining patient privacy and confidentiality. For this reason, filming should only proceed when the patient (or the patients’ surrogate decision-maker) and all medical staff treating the patient, explicitly consent to the filming.

## Recommendations

The Council recommends that the following be adopted and the remainder of the report be filed:

The use of any medium to record (hereafter film) patient interactions with their health care providers requires the utmost respect for the privacy and confidentiality of the patient. The following guidelines are offered to assure that the rights of the patient are protected. These guidelines

1 specifically address filming with the intent of broadcast for public viewing, and do not address other  
2 uses such as in medical education, forensic or diagnostic filming, or the use of security cameras.

3  
4 (1) Educating the public about the health care system should be encouraged, and filming of patients  
5 may be one way to accomplish this. This educational objective is not severely compromised by  
6 filming only patients who can consent, and when patients cannot consent, dramatic reenactments  
7 utilizing actors should be considered instead of violating patient privacy.

8  
9 (2) Filming patients without consent is a violation of the patient’s privacy. Consent is therefore an  
10 ethical requirement for both initial filming and subsequent broadcast for public viewing. Because  
11 filming cannot benefit a patient medically, and moreover has the potential of causing harm to the  
12 patient, it is appropriate to limit filming to instances where the party being filmed can explicitly  
13 consent. Consent by a surrogate decision-maker is not an ethically appropriate substitute for  
14 consent by the patient because the role of surrogates is to make medically necessary decisions in  
15 the best interest of the patient. A possible exception exists when the person in question is  
16 permanently or indefinitely incompetent (e.g. permanent vegetative state or minor child). In such  
17 circumstances, if a parent or legal guardian provides consent, filming may occur.

18  
19 (a) Patients should have the right to have filming stopped upon request at any time and the film  
20 crew removed from the area. Persons involved in the direct medical care of the patient who  
21 feel that the filming may jeopardize patient care should also request that the film crew be  
22 removed from the patient care area.

23  
24 (b) The initial granting of consent does not preclude the patient from withdrawing consent at a  
25 later time. After filming has occurred, patients who have been filmed should have the  
26 opportunity to rescind their consent up until a reasonable time period before broadcast for  
27 public viewing. The consent process should include a full disclosure of whether the tape will  
28 be destroyed if consent is rescinded, and the degree to which the patient is allowed to view  
29 and edit the final footage before broadcast for public viewing.

30  
31 (c) Due to the potential conflict of interest, informed consent should be obtained by a  
32 disinterested third party, and not a member of the film crew or production team.

33  
34 (3) Information obtained in the course of filming medical encounters between patients and physicians  
35 is confidential. Persons who are not members of the healthcare team, but who may be present for  
36 filming purposes, must demonstrate that they understand the confidential nature of the  
37 information and are committed to respecting it. Where possible, it is desirable for stationary  
38 cameras or health care professionals to perform the filming.

39  
40 (4) Physicians, as advocates for their patients, should not allow financial or promotional benefit to  
41 the health care institution to influence their advice to patients regarding participation in filming.  
42 Because physician compensation for participation in filming may cause an undue influence to  
43 recruit patients, physicians should not be compensated directly. To protect the best interests of  
44 patients, physicians should participate in institutional review of requests to film.

## REFERENCES

1  
2  
3 *A draft of this report was circulated to the ethics committee of the American College of Emergency*  
4 *Physicians.*

- 5  
6 1. Council on Ethical and Judicial Affairs, A.M.A., *Opinion 5.04, Communications Media: Standards of Professional Responsibility*, in *Code of Medical Ethics: Current Opinions with Annotations*. 2000, American Medical Association: Chicago.
- 7  
8  
9 2. Council on Ethical and Judicial Affairs, A.M.A., *Opinion 5.05, Confidentiality*, in *Code of Medical Ethics: Current Opinions with Annotations*. 2000, American Medical Association: Chicago.
- 10  
11  
12 3. *Green v. Chicago Tribune Co.* 1996, Illinois App. 1st dist. 1st Div.
- 13 4. *Black's Law Dictionary*. 6th ed. 1991.
- 14 5. *Miller v. National Broadcasting Corp.* 1986, Cal. App.
- 15 6. American College of Emergency Physicians, Ethics Committee, *Recorded images: Use and abuse in the emergency department*. 2001, *In press*.
- 16  
17 7. Foubister, V., *Acting in the ER*, in *AMNews*. 2000: Chicago.
- 18 8. Holston, N., *Lights, camera, scalpel*, in *Star Tribune*. 2000: Minneapolis. p. 1B.
- 19 9. *Virgil v. Time Inc.*. 1975, 9th Circuit US App.
- 20 10. Council on Ethical and Judicial Affairs, A.M.A., *Opinion 8.08, Informed Consent*, in *Code of Medical Ethics: Current Opinions with Annotations*. 2000, American Medical Association: Chicago.
- 21  
22  
23 11. *Guidelines for Videotaped Documentation of Episodes of Medical Care*, in *Interagency Committee for Medical Records*. 1999: Washington, DC. p. 68110.
- 24  
25 12. JCAHO, *Patient rights and informed consent when videotaping or filming*. 2000, JCAHO: Chicago.
- 26  
27 13. Nord, T., *Louisville's Own 'ER'*, in *The Courier-Journal*. 2000: Louisville, KY. p. 01C.
- 28 14. Folfenflik, D., *Under the microscope*, in *The Baltimore Sun*. 2000: Baltimore. p. 1E.
- 29 15. Brodie, M., et al., *Communicating health information through the entertainment media*. *Health Affairs*, 2001. **20**(1): p. 192-199.
- 30  
31 16. Diem, S.J., J.D. Lantos, and J.A. Tulskey, *Cardiopulmonary resuscitation on television. Miracles and misinformation [see comments]*. *N Engl J Med*, 1996. **334**(24): p. 1578-82.
- 32  
33 17. Kassirer, J.P., *Patients are the Losers in this reality TV show*, in *The Boston Globe*. 2000: Boston. p. A17.
- 34  
35 18. Schumacher, W.C., *Lights! Camera! Blood! Action!*, in *The Wall Street Journal*. 2000: New York.
- 36

